IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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February 9, 2010

Josiah Dahlstrom
Beacon Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

RE: Beacon Hospital Of Pocatello, provider #134011

Dear Mr. Dahlstrom:

This is to advise you of the findings of the complaint survey at Beacon Hospital Of Pocatello which was concluded on January 28, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **February 22, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134011	A. BUILDING _____ B. WING _____	C 01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your hospital. The surveyors conducting the survey were: Teresa Hamblin, RN, MS, Team Leader Trish O'Hara, RN, HFS The following abbreviations were used in the report: CPR = cardiopulmonary resuscitation RN = Registered nurse	A 000	RECEIVED FEB 22 2010 FACILITY STANDARDS	
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies and personnel restraint training records, it was determined the hospital failed to ensure 6 of 27 direct care staff (#2, #5, #22, #23, #24, and #25) were current in restraint competencies. This directly impacted one patient (#2) reviewed who was restrained by a staff member whose Mandt certification had expired. It had the potential to compromise the quality and safety of patient care. Findings include:	A 196	**A 196** The Director of Staff Development (DSD) has In-serviced all hospital staff to reinforce the Restraint and Seclusion polices. They have also been in-serviced that if they are not current in MANDT day 1 & 2 they cannot participate in any Restraint or Seclusion. All employees will be MANDT certified during the orientation period and at least annually thereafter. Any not currently MANDT certified at the time the survey was conducted have been trained and received the necessary certification that will allow them to participate in any needed seclusion or restraint. The DNS will ensure compliance moving	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Josiah Dahlstrom — TITLE: Administrator — (X6) DATE: 2/19/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 196	Continued From page 1 A hospital policy, "Restraints," dated 6/10/09, referred to the "Mandt training" for information related to restraint interventions, such as the "Staff Holding Technique," and the "Transport Technique". The hospital restraint-related policy, "Mandt Training," dated 8/21/09, described Mandt training as a non-violent crisis intervention system designed to facilitate the safest environment for patients and staff and to protect the rights and dignities of hospitalized patients. Day 1 of training focused on conceptual aspects, such as how to build healthy relationship, communication, conflict resolutions, etc., while Day 2 focused on technical skills (including restraint procedures) required. After completing both days, employees received certification in the training. The certification required renewal after 12 months. During an interview with the Director of Staff Development on 1/28/10 at 10:40 AM, she explained that all direct care staff were expected to receive "Mandt" training at hire and annually thereafter. Some of the staff were only required to complete the first day while others were required to complete both days of training. When asked for information to verify staff's current restraint competencies, the Director of Staff Development presented a roster of 27 direct care staff. During an interview on 1/28/10 at 2:15 PM, she stated that in reviewing staff education records, she found that 6 out of 27 employees (#2, #5, #22, #23, #24, and #25) were not current on their annual recertification for Mandt training. Two of the employees were RNs (#2 and #5) while 4 of the employees were non-RN clinical staff (#22, #23, #24, and #25). There was evidence in the restraint records that one of the RNs (Staff #2) had restrained Patient #2 on 3	A 196	forward by receiving from the DSD a typed or written list of all staff and their certification and any set to expire in the next 4 months will be scheduled for a renewal prior to the expiration date. This audit will be presented to the Medical Executive Committee on a quarterly basis as a further measure to ensure compliance.	**03-10-10**

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A 196	Continued From page 2 occasions (12/13/09, 12/28/09, 12/29/09) after his annual certification of Mandt training had expired June 30th, 2009. Restraint documentation for a restraint incident that occurred on 12/13/09 involving Staff #2 and Patient #2, documented Patient #2 sustained a "bruised lip" as a result of restraint. During an interview with the Director of Staff Development on 1/28/10 at 11:30 AM, she stated that Staff #2 should not have participated in restraining patients until he was recertified. During an interview on 1/28/10 at 11:50 AM, the Director of Nursing also confirmed the lapse in Staff #2's Mandt training certification.	A 196		
A 206	482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies, and personnel records, it was determined the hospital failed to ensure 9 out of 27 direct care staff (#8, #9, #11, #14, #16, #17, #22, #23, and #27) had evidence of current CPR certification. It also failed to ensure that 27 out of 27 direct care staff (#s 1-27) had evidence of first aid training specific to the needs of restrained patients. This had the potential to compromise the quality and safety of patient care. Findings include:	A 206	**A 206** The Director of Staff Development (DSD) has In-serviced all hospital staff to reinforce the Restraint and Seclusion polices. They have also been in-serviced that if they are not current in CPR and facility program first aid they cannot participate in any Seclusion and/or Restraint. All employees will be CPR and First Aide certified during the orientation period, prior to involvement in any seclusion and restraint and then as often as required to keep their certification up to date. Any not currently CPR or First Aide Certified at the time the survey was conducted have been trained and received the	

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A 206	Continued From page 3 Surveyors requested evidence of current CPR competencies for direct care staff. During an interview with the Director of Staff Development on 1/28/10 at 2:45 PM, she stated that 9 out of 27 direct care staff (#8, #9, #11, #14, #16, #17, #22, #23, and #27), all of whom were non-RN clinical staff, were not current on their CPR certification. She explained that it had not been their policy or practice to require non-RN clinical staff to have current CPR certification. She stated she did not realize it was a requirement. She also stated, during the above referenced interview, that she was not aware of the requirement that all direct care staff involved with restraints were required to have first aid training. She explained that the hospital had not provided or tracked first aid training with any staff. Therefore there was no evidence of first aid training for the 27 employees (#s 1-27) who provided direct patient care. During the interview, the Director of Staff Development and the Director of Nursing stated they would develop and deliver appropriate first aid training to direct care staff in order to be in compliance with the requirements. A hospital policy, "Restraints," dated 6/10/09, stated that an appropriate number of staff would be available at all times who were competent to initiate first aid and CPR. It did not specifically state that all staff involved with caring for restrained patients were expected to be current in CPR certification and be trained in first aid. During an interview on 1/28/10 at 2:45 PM, the Director of Nursing stated he would update the policy to more accurately reflect the requirement for all direct care staff to have first aid and CPR	A 206	necessary certification that will allow them to participate in any needed seclusion or restraint. The facility policy has been changed to reflect that all direct care staff involved in restraints must be certified in CPR and First Aide. The DNS will ensure compliance moving forward by receiving from the DSD a typed or written list of all staff and their CPR and First Aide certification and any set to expire in the next 4 months will be scheduled for a renewal prior to the expiration date. This audit will be presented to the Medical Executive Committee on a quarterly basis as a further measure to ensure compliance.	**03-10-10**

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A 206	Continued From page 4 training.	A 206		

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FILE COPY

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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February 10, 2010

Josiah Dahlstrom
Beacon Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Provider #134011

Dear Mr. Dahlstrom:

On **January 28, 2010**, a complaint survey was conducted at Beacon Hospital Of Pocatello. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004030

Allegation: A staff member physically abused a patient by pulling her hair.

Findings: An unannounced visit was made to the facility on 1/28/10. Clinical records, facility policies, grievance log, and personnel and education records were reviewed. Staff was interviewed and patient care observations were done.

One personnel record showed a grievance had been filed with the facility on 2/16/09, stating a Certified Nurse Assistant (CNA) had physically abused a patient by pulling her hair. The patient had been admitted to the facility on 2/12/09 for treatment of dementia, depression and increasing aggressive behaviors. The facility had a policy titled "Abuse or Neglect allegations", dated 1/31/04 with review on 8/21/09. It stated, "If the suspected perpetrator is a hospital employee or staff member, the suspected perpetrator will be immediately suspended pending a thorough investigation." Facility policy was followed and the CNA was suspended. Adult Protection was contacted to objectively investigate the complaint. The facility administrator stated, in an interview on 1/28/10 at 2:00 PM, that this was the facility's normal mode of investigation. Investigative information indicated the CNA had pushed the patient's head away from her in order to avoid being bitten by the patient.

The CNA had been working at the facility for three months and had not yet received training in dealing with aggressive behaviors.

The charge nurse involved in this situation was interviewed during the survey. She said the patient often liked a staff member one day and disliked the same staff member the next day and might say she was afraid of someone she did not like. She further stated the patient would focus aggressive behaviors on staff members without provocation. The nurse also said the patient would become aggressive and manipulative toward staff members providing care, often hitting, spitting and biting. She cited interventions that were helpful to staff in de-escalating the patient, but also stated the CNA had not been educated in these interventions at the time of the event.

The facility's policy titled "Abuse or Neglect allegations", dated 1/31/04 with review on 8/21/09, further stated, "Interventions and plans will be discussed to prevent future incidents of abuse. Inservices and trainings will be planned and implemented to help the staff monitor and prevent potentially abusive situations." This was done. The CNA received Mandt training. This was a two day training that taught staff members about non-physical interventions to use in response to aggressive behaviors and how to manage aggressive behaviors if non-physical interventions were unsuccessful. There was no facility policy in place at the time of the incident addressing the mandatory requirement of Mandt training by staff members. However, a policy was created and instituted on 8/21/09 which required all staff members to receive 2 days of Mandt training within 90 days of hire and before the staff member had any physical interactions during escalation episodes with patients.

It was determined the incident may have occurred, however, no citations were issued as the facility had taken appropriate corrective actions prior to the complaint investigation survey.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.
Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

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February 9, 2010

Josiah Dahlstrom
Beacon Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Provider #134011

Dear Mr. Dahlstrom:

On **January 28, 2010**, a complaint survey was conducted at Beacon Hospital Of Pocatello. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004497

Allegation: The hospital failed to ensure direct care staff used restraints appropriately and excessive force was not used.

Findings: An unannounced visit was made to the hospital, entering and exiting on 1/28/10. During the complaint investigation, surveyors interviewed staff, toured the facility, observed interactions between staff and patients, and reviewed 7 patient records (2 current patients and 5 patients already discharged). In addition, they reviewed hospital policies, administrative meeting minutes, documentation related to restraint incidents, employee files, education records, and content of restraint educational material utilized by the facility.

Hospital Tour and Observations of Staff-Patient Interactions:

Surveyors toured the hospital on 1/28/10 at approximately 4:00 PM. At the time of the tour, the patient census was 9 patients. Staffing included 1 registered nurse and 4 nursing assistants/technicians. Staff were observed to be interacting with patients. The atmosphere in the unit was calm.

When asked during the tour, how the hospital adapted to a sudden crisis requiring additional staff, the Director of Nursing stated that several other staff members were prepared to step in to provide 1:1 support with patients when needed. He stated that some members of the medical record department were also certified nursing assistants, and that he (as Director of Nursing) and the Nurse Educators were also available. The Director of Nursing stated he preferred to "overstaff" in order to allow the possibility of 1:1 staffing as needed. It was determined the hospital provided sufficient staff to support quality and safety of patient care.

Restraint Documentation:

Restraint and Seclusion logs for the months of October through December 2009 and January 2010 (to the date of investigation) documented 7 restraint incidents involving 3 patients. Two of the patients were restrained one time each. A third patient was restrained 5 separate times. Four of the 5 incidents occurred during the month of December 2009 and 1 restraint incident occurred during the month of January 2010.

Restraint documentation was determined to be thorough and provided enough information to supervisory staff to determine if changes needed to be made to the patient's plan of care, whether staff followed restraint protocols appropriately, and whether individual staff members needed further education, reprimand, or redirection in their approproaches. Restraint documentation included the following information: a) reason for restraints; b) type of restraints; c) a time limit duration; d) reasons to discontinue the restraints; e) less restrictive alternative tried prior to restraint use; f) the plan of care for restrained patients; g) evidence of monitoring the restrained patients; h) a restraint review tool utilized to evaluate appropriateness of how the restraint was handled; i) and patient debriefing process documentation. The two most recently documented restraint incidents, dated 1/10/10 and 1/21/10, also included written statements from staff members involved with the restraint incidents describing their perceptions of events related to the restraint incidents.

Internal Identification of a Problem and Measures to Correct the Problem:

During an interview with the Director of Nursing on 1/28/10, he explained that he became aware of a staff member (an RN) who had recently handled restraints in a questionably appropriate manner. In response to the concern, he explained an internal investigation was initiated, staff were interviewed, Adult Protective Services was contacted and appropriate disciplinary action was initiated. Additional training was also provided to the employee. The Director of Nursing provided paperwork to validate the process he described.

Hospital Policies:

The hospital policy, "Restraints," dated 6/10/09, was a 13 page document that detailed: 1) the policy; 2) the purposes of the policy; 3) definitions; 4) initial patient assessment; 5) initiation of seclusion and restraint; 6) continuation of seclusion and restraint; 7) release from seclusion and restraint; 8) documentation expectations; 9) nursing responsibilities; 10) post restraint and seclusion activities; 11) reporting and reviewing; 12) restraint training requirements. The policy referred to a second policy, "Mandt Training."

The "Mandt training" policy, dated 8/21/09, described Mandt training as a non-violent crisis intervention system designed to facilitate the safest environment for patients and staff and to protect the rights and dignities of hospitalized patients. Day 1 of training focused on conceptual aspects, such as how to build healthy relationship, communication, conflict resolutions, etc., while Day 2 focused on technical skills (including restraint procedures). required. After completing both days, employees received certification in the training. The certification required renewal after 12 months.

During an interview on 1/28/10 at 9:30 AM the Director of Nursing explained that the hospital had reviewed and rebuilt their restraint policy in July of 2009 in response to a Federal survey. He explained the facility did not seclude patients and had not done so in at least 6 years. He also stated that the hospital did not use mechanical restraints except as rarely needed as a medical restraint. He explained that the hospital routinely dealt with patient violence, stating "people slug at us every day." He stated that in the past two weeks, the hospital had implemented a new process in response to an incident where some staff felt one staff member had used excessive force. In order to create an environment that encouraged staff disclosure of concerns, they began a process of debriefing staff involved in a restraint incident. The new process was intended to give staff an opportunity to express any concerns about how the event was handled and to evaluate the need for any corrective measures. He described a recent restraint incident involving a patient that he described as "questionable" about how a patient was handled by a staff member.

It was determined the hospital had well developed restraint policies and did not hesitate to update them as they became aware of the need. For example, the hospital was in the process of adding to the "Restraints" policy the process of debriefing with staff. According to the Director of Nursing during an interview on 1/28/10, the changes had been proposed but not yet approved.

Restraint Education:

The hospital restraint-related policy, "Mandt Training," dated 8/21/09, described Mandt training as a non-violent crisis intervention system designed to facilitate the safest environment for patients and staff and to protect the rights and dignities of hospitalized patients. Day 1 of training focused on conceptual aspects, such as how to build healthy relationship, communication, conflict resolutions, etc., while Day 2 focused on technical skills (including restraint procedures). After completing both days, employees received certification in the training. The certification required renewal after 12 months. During an interview with the Director of Staff Development on 1/28/10 at 10:40 AM, she explained that all direct care staff were expected to receive "Mandt" training at hire and annually thereafter. Some of the staff were only required to complete the first day while others were required to complete both days of training. After reviewing the Mandt Training material, it was determined the training was designed to facilitate a safe environment for patients and staff and to protect the rights and dignities of patients.

Employee Education Records:

When asked for information to verify current restraint competencies, the Director of Staff Development presented a roster of 27 direct care staff. In reviewing staff education records, it was determined that 6 out of 27 employees were not current on their annual recertification for Mandt training. Two of the employees were RNs while 4 of the employees were non-RN clinical staff. One of the RNs had restrained patients after the annual certification of Mandt training had expired. There was no evidence the other 5 staff members had restrained patients since their certifications had expired.

In addition, it was determined through review of personnel records and interview with staff, the hospital failed to ensure all direct care staff had evidence of current CPR certification and first aid training specific to the needs of restrained patients.

It could not be determined the hospital failed to ensure staff appropriately used restraints. Processes were in place to guide and educate staff and to identify problems and ensure correction. However, the hospital was cited at CFR 482.12(f)(1) and CFR 482.13(f)(2)(vii) for failure of the hospital to ensure all appropriate staff were current on restraint re-certification, CPR recertification, and first aid training.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw